STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445358	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEBRIDGE HEALTH CARE CENTER	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed corridor doors to residents rooms 205 and 510 failed to close to a positive latch.	K 018	**K 018** Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas Corridor doors to resident rooms 205 and 510 were adjusted on 7/22/13 and are latching properly. Identification of Other Areas with Potential to be Affected Facility doors, in addition to rooms 205 and 510, were checked by the Maintenance Director on 7/22/13 and were found to be latching properly. Systematic Changes Measures to assure compliance include monthly Performance Improvement audits by the Administrator and Maintenance Director to insure doors latch properly. Monitoring Results of these audits will be reported monthly to the Performance Improvement Committee for review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nyda Davis	Administrator	7/24/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed corridor doors to residents rooms 205 and 510 failed to close to a positive latch.	K 018	and recommendations. The Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director.	7/26/13

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K 018	Continued From page 1 These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined corridor fire doors were held open by approved devices. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:20 p.m. and 11:00 p.m. confirmed both pairs of fire doors from dining room, back hall, and the fire doors by room 510 would not close to a positive latch. These findings were verified by the Maintenance	K 021	**K 021** Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas Fire doors from the dining room, back hall, and by room 510 were repaired by the facility Maintenance Director on 7/16/13, and they close to a positive latch when the facility's fire alarm is activated. Identification of Other Areas with Potential to be Affected Fire doors, in addition to those listed above, were checked by the Maintenance Director on 7/18/13 and 7/22/13, and were found to be latching properly.	

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K 021	Continued From page 2 Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 021	Systematic Changes Measures to assure compliance include monthly Performance Improvement audits by the Administrator and the Maintenance Director. They will audit to ensure doors latch properly when the fire alarms are activated. Monitoring The Maintenance Director will report the results of these audits monthly to the Performance Improvement Committee for review and recommendations. This Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director to assure compliance.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 at 9:00 p.m. confirmed the Clinical records room door was not provided with a door closer. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 029	K 029 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care,	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 021	Continued From page 2 Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 021	but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 at 9:00 p.m. confirmed the Clinical records room door was not provided with a door closer. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 029	Corrective Actions for Targeted Areas A door closer was installed by the facility Maintenance Director on the clinical records room door on 7/18/13. Identification of Other Areas with Potential to be Affected Other doors that require a door closer were audited by the facility Maintenance Director on 7/18/13, and were found to be in compliance. Systematic Changes The Maintenance Director was in-serviced by the facility Administrator on 7/18/13 regarding the requirement for positive latch door closers. Monitoring The Maintenance Director will audit facility doors monthly for three months to assure that doors requiring door closers are in compliance. Results of the audits will be reported to the Performance Improvement Committee for review and recommendations. This Committee consists of the Administrator, Medical Director, Director of	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure eight (8) of twelve (12) delayed egress doors would release upon activation of the fire alarm. Findings include: Observation and interview during the fire drill with the Maintenance Director, on July 15, 2013 at 9:30 p.m. confirmed exit doors with delayed-egress magnetic locking hardware failed to release with fire alarm activation by the beauty shop, by rooms 605, 208, 713, kitchen exit, by social services office, main entrance and dining room. Three (3) of ten (10) staff interviewed did know the code for releasing the doors. The Therapy gym delayed egress function failed to operate. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 038	Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director to assure compliance. **K 038** Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas It was determined that the cited delayed-egress magnetic locking hardware relays were damaged due to a recent power surge. The cited delayed-egress magnetic locking hardware was repaired by the facility's contracted vendor, Fleenor Security, on 7/16/13.	7/26/13
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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K 038	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure eight (8) of twelve (12) delayed egress doors would release upon activation of the fire alarm. Findings include: Observation and interview during the fire drill with the Maintenance Director, on July 15, 2013 at 9:30 p.m. confirmed exit doors with delayed-egress magnetic locking hardware failed to release with fire alarm activation by the beauty shop, by rooms 605, 208, 713, kitchen exit, by social services office, main entrance and dining room. Three (3) of ten (10) staff interviewed did know the code for releasing the doors. The Therapy gym delayed egress function failed to operate. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 038	Identification of Other Areas with Potential to be Affected Other doors with delayed-egress magnetic locking hardware have the potential to be affected. Systematic Changes Facility staff were in-serviced on 7/19/13 regarding the codes for delayed-egress magnetic locking doors. As codes change, staff will be again in-serviced regarding proper codes. New staff will be in-serviced upon new employee orientation regarding proper codes. The Maintenance Director will audit delayed-egress magnetic locking hardware weekly to assure compliance. Monitoring The Maintenance Director will report results of the above audits monthly to the facility's Performance Improvement Committee for review and recommendations. This Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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K 038	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure eight (8) of twelve (12) delayed egress doors would release upon activation of the fire alarm. Findings include: Observation and interview during the fire drill with the Maintenance Director, on July 15, 2013 at 9:30 p.m. confirmed exit doors with delayed-egress magnetic locking hardware failed to release with fire alarm activation by the beauty shop, by rooms 605, 208, 713, kitchen exit, by social services office, main entrance and dining room. Three (3) of ten (10) staff interviewed did know the code for releasing the doors. The Therapy gym delayed egress function failed to operate. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 038	by the Administrator and the Maintenance Director to assure compliance.	7/26/13
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	**K 045** Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas The cited outside courtyard lights/bulbs and the wall-mounted light were replaced on 7/18/13. Identification of Other Areas with Potential to be Affected Outside lighting in the courtyard and other areas have the potential to be affected.	

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K 045	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit paths were lighted. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 at 9:40 p.m. confirmed the outside courtyard lights failed to illuminate the means of egress to exit the courtyard and the wall mounted light was burnt out. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 045	Systematic Changes On 7/18/13, the facility's outside lighting was checked by the Maintenance Director and was found to be functioning properly. The Maintenance Director will audit facility lighting monthly to assure compliance. Monitoring The Maintenance Director will report audit results monthly to the Performance Improvement Committee for review and recommendations. This Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director to assure compliance.	7/26/13
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Automatic Transfer switch location was provided with battery-powered emergency lighting. The findings include:	K 144	K 144 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation	

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K 144	Continued From page 5 Observation and interview with the Maintenance Director, on July 15, 2013 at 10:40 p.m. confirmed the emergency generator Automatic Transfer switch location was not provided with battery-powered emergency lighting. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013	K 144	from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas The automatic transfer switch location had emergency lighting on the date of the survey. Unfortunately, during survey, it was not located nor indicated to the surveyor.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prohibit the use of extension cords. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:30 p.m. and 10:10 p.m. confirmed the use of extension cords in resident rooms 207, 505, and 711. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 147	Identification of Other Areas with Potential to be Affected The emergency generator could be affected if lighting was not provided for the automatic switch. Systematic Changes On 7/18/13, the emergency lighting provided for the emergency transfer switch was audited by the Maintenance Director and was found to be in proper functioning order. The Maintenance Director will audit monthly the facility's emergency lighting to assure it is functioning properly. Monitoring The Maintenance Director will report audit results monthly to the Performance Improvement Committee for review and recommendations. This Committee consists of the Administrator, Medical Director,	

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K 144	Continued From page 5 Observation and interview with the Maintenance Director, on July 15, 2013 at 10:40 p.m. confirmed the emergency generator Automatic Transfer switch location was not provided with battery-powered emergency lighting. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013	K 144	Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director to assure compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prohibit the use of extension cords. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:30 p.m. and 10:10 p.m. confirmed the use of extension cords in resident rooms 207, 505, and 711. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 147	**K 147** Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Areas Extension cords were removed immediately by the Maintenance Director from resident rooms 207, 505, and 711. Identification of Other Areas with Potential to be Affected Resident rooms, in addition to rooms 207, 505, and 711, were checked by the	7/26/13

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LAKEBRIDGE HEALTH CARE CENTER	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 Observation and interview with the Maintenance Director, on July 15, 2013 at 10:40 p.m. confirmed the emergency generator Automatic Transfer switch location was not provided with battery-powered emergency lighting. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013	K 144	Maintenance Director on 7/18/13 to ensure that no other rooms had extension cords, and none were found. Systematic Changes Weekly room audits will be completed by the Maintenance Director and Administrator to ensure that resident rooms meet life safety code standard, including assurance that no extension cords are in place. Monitoring The Maintenance Director will report audit results monthly to the Performance Improvement Committee for review and recommendations. This Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director to assure compliance.	7/26/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prohibit the use of extension cords. The findings include: Observation and interview with the Maintenance Director, on July 15, 2013 between 7:30 p.m. and 10:10 p.m. confirmed the use of extension cords in resident rooms 207, 505, and 711. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 15, 2013.	K 147		

JUL 24 2013